# Principle #2: Paying for Health Care Reform
## June 18, 2009

Given the precarious fiscal position of the country, it is critical that any efforts to reform the nation's health care system are fiscally responsible. Accordingly, the Committee for a Responsible Federal Budget has developed a list of principles for enacting reform:

1) Health Care Reform Should Focus on Slowing Cost Growth
2) New Government Health Care Spending Should be Fully Offset
3) Government Health Care Programs Must be Made Sustainable
4) The Need to Reform Health Care Does Not Displace the Need to Reform Other Areas of the Budget
5) Health Care Reform is a Continuous Process and Will Require Continued Vigilance from Policymakers

In our previous health care paper, *Principle #1: Slowing Health Care Cost Growth* (http://www.crfb.org/documents/Health_Principle_1.pdf), we argue that controlling growing health care costs must be at the center of any health care reform plan. If unchecked, health care costs, which have been growing faster than the economy, will contribute to unsustainable levels of government spending, and produce unmanageable costs for the overall health system.

In addition to controlling our nation's existing commitments, health care reform must not introduce any new unfunded commitments.

This is the time to be reducing, not increasing, the nation's unfunded liabilities. We should be focused on putting the budget on a sustainable path, not on adding new government entitlement programs. But given the political commitment to expanding health insurance coverage as part of comprehensive health care reform, ***it is absolutely necessary that any new costs to the government be fully offset*** – and a comprehensive health care reform plan should reduce the long-term deficit.

We agree with the Administration's stated view that "health care reform must be deficit neutral over the next decade. That means that every dollar spent on this effort must be paid for – with real savings or revenue proposals that can be scored by the Congressional Budget Office (CBO). The offsets are not in any way theoretical; they are specific proposals that have been determined by CBO to reduce spending or raise revenue."

In our view, pay-as-you-go (PAYGO) rules should be the minimum standard for new health legislation. At the very least, responsible health care reform should be deficit neutral over five and ten years, and should reduce the overall budget deficit in subsequent years. Enforcement mechanisms, perhaps in a form similar to sequestration, should be in place to scale back the government's health care commitments if these goals are not achieved.

Meeting this standard will not come easily. Health care expansion will not pay for itself through system rationalizing, and even aggressive general health care cost control measures cannot achieve enough public savings over the next decade to compensate for new costs of the types of plans that are being discussed.

Health care reform is going to be a costly endeavor. The plans being considered would cost over $100 billion a year. The Congressional Budget Office has said, "such proposals could permanently boost the government's budgetary commitments to health care by something in the vicinity of 10 percent." If we proceed down the path of coverage expansion, hard choices will have to be made on cutting spending, increasing taxes, or scaling back plans to expand and subsidize health care coverage. Given the trillion dollar deficits we currently face, failure to pay for a large new entitlement would be extremely dangerous for our country's financial future – and plunge us deeper into an era of unsustainable debt.

## The Cost of Reform

Given the goal of expanding health care coverage, health care reform promises to be expensive, at least over the short run. Although expanding coverage can put some downward pressure on costs by expanding the risk pool and decreasing emergency room costs, any such savings are dwarfed by the costs of covering the nation's uninsured and subsidizing many already insured individuals. Even active measures to slow economy-wide health care cost growth will take time to play out, and are unlikely to dramatically decrease public health care spending over the next decade. Expanding coverage, while admirable, will no doubt increase health care spending significantly.

**Fig. 1: Cost Estimates for Select Health Care Reform Plans (billions)**

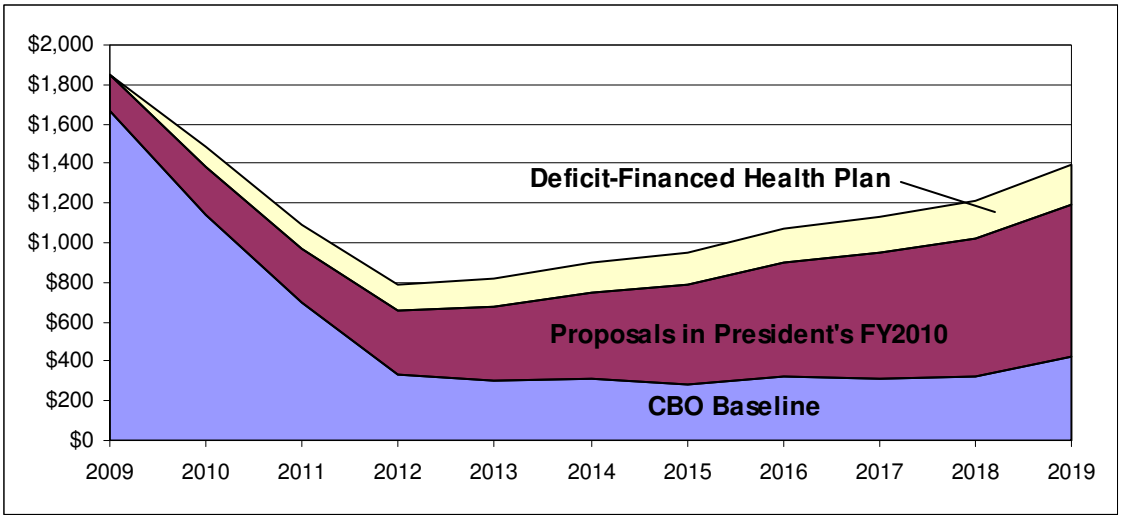
| Plan | Estimator | 10-Year Cost |
|---|---|---|
| Obama Campaign Plan | Lewin Group | $1,509 |
| | Tax Policy Center | $1,630 |
| "Medicare for All" (Dingell) | Lewin Group | $1,232 |
| "Health Care for America" (Hacker) | Lewin Group | $534 |
| "Affordable Health Care Choices Act" (Kennedy/HELP Committee) | Congressional Budget Office (Preliminary) | $1,042 |
| Obama Administration "Down Payment" on Health Reform | Office of Management and Budget | $948 |

## The Precarious Fiscal Situation

Although troublesome in any fiscal circumstance, creating a large and permanent deficit-financed program would be particularly dangerous in the current climate. This year, the budget deficit is expected to hit $1.8 trillion, or 12.9 percent of GDP. This is almost four times the previous nominal record of $459 billion set in 2008, and more than double the post-war record as a percent in GDP, set at 6 percent in 1983. A portion of this short-term deficit is an intentional economic stimulus, and its full magnitude may prove to be useful in boosting the flagging economy. But the problem goes beyond the current stimulus. Large structural deficits are projected to persist over the next decade, at which point the economic effect of running deficits will be damaging rather than stimulative.

Under the President's budget, deficits would total $9.1 trillion between 2010 and 2019, and never drop far below $650 billion in any given year. Debt held by the public is projected to grow from 41 percent of GDP in 2008 to 82 percent by 2019. Over the medium- and long-run, this debt promises to slow economic growth by crowding out public investment and adding significantly to federal interest payments.

**Fig. 2: Deficit Projections (billions)**



Worries over budget deficits, in fact, have already led so-called "bond vigilantes" to demand higher interest rates on long-term U.S. debt, even before a recovery takes hold.

Policy makers should be focused on reducing the deficit, not increasing it. Failing to fully pay for the costs of new permanent health policies would be a mistake, as deficit-financed health reforms would only dig our fiscal hole deeper.

## The Need for PAYGO

The Obama Administration has already promised to fully pay for the costs of its health care plan, and more generally has called for reinstating statutory PAYGO. Some outside groups and individuals, though, have put pressure on the Administration and the Congress to waive PAYGO for health care reform. Those who oppose fully paying for health care expansion generally rely on three arguments: 1) CBO scoring is too conservative; 2) health care reform will pay for itself over the long-term; 3) health care reform is too important to worry about paying for.

On the first point, it is important to note that CBO is considered *the* authoritative nonpartisan budget group. In such a complex system, the actual effects of a given policy are highly uncertain, and CBO's estimates will not be perfect. But their scoring takes into account behavior changes – including those on the part of patients, providers, employers, workers, insurers, and state governments – based on the best available evidence. Moreover, they look not only at the savings that may be produced from a given cost-reducing policy, but also at the additional costs imposed – often from higher demand as a result of lower prices or from increased life expectancy.

As for the second argument, we would point out that not only are future savings highly uncertain, but they are projected to come mainly from Medicare and Medicaid. Since these programs are already on dangerously unsustainable paths, future health care savings will be needed simply to keep them viable, and so should not be used to finance unnecessary past borrowing. And finally, if health care reform is as important as advocates suggest, it should be easier – not harder – to pay for. Taxpayers and beneficiaries of government programs should be willing to give up more in exchange for comprehensive health care reform.

Given this, we support President Obama and the members of Congress who believe in fully paying for new health care spending with scoreable offsets. In our view, though, legislation should have to be at least deficit-neutral over five as well as ten years, to prevent back-loading offsets which may never come to be, or dangerously enlarging the deficit during that five year period. It is also important that the costs do not balloon in the next ten-year period, due to a slow phase-in of coverage expansion or budget gimmicks used to mask the full costs. The Congressional Budget Office has warned of this risk, since many offsets used to pay for health care reform would grow more slowly

than would health care costs. Beyond the ten year window, any health reform plan must be deficit-reducing, and this should be enforced through a budgetary mechanism that would come into play if costs grow too high or savings are too small.

## An Exercise in Hard Choices

Paying for health care reform means making hard choices. Specifically, it will require raising taxes, cutting spending, scaling back the size of a health care reform plan, and/or proposing major reforms to dramatically reduce system-wide health care spending.

Revenue options can focus on scaling back or eliminating current tax benefits for health care, increasing other existing taxes, or establishing new ones. Spending options can focus on reducing the size or scope of federal health programs, reducing their spending through payment or general health care reforms, or cutting spending elsewhere in government. And reform plans can be scaled back by reducing the size of subsidies, focusing them more narrowly, reducing the standard provided insurance package, or relying more heavily on regulatory rather than budgetary actions.

**Fig. 3: The President's Health Care Reserve Fund (billions over ten years)**

| Policy Proposals | OMB | CBO/JCT |
|---|---|---|
| Institute Competitive Bidding for Medicare Advantage | $177 | $176 |
| Increase Premiums for High-Income Enrollees Medicare Part D | $8 | $8 |
| Reallocate Medicare and Medicaid Improvement Funds | $24 | $23 |
| Encourage Hospitals to Reduce Readmission Rates | $8 | $6 |
| Create Hospital Quality Incentive Payments | $12 | $11 |
| Bundle Certain Medicare Payments, Especially for Acute Care | $18 | $18 |
| Promote Cost-Effective Purchase of Medicaid Prescription Drugs | $20 | $16 |
| Promote Increased Use of Generic Biologics | $6 | $5 |
| Improve Medicare Home Health Payments | $34 | $51 |
| Other Spending Changes and Interaction Effects | $1 | -$17 |
| ***Spending Reductions in the President's Budget*** | ***$309*** | ***$297*** |
| Limit Tax Rate for Itemized Deductions | $267 | $269 |
| Expand Information Reporting to Reduce the Tax Gap and Improve Compliance | $10 | $4 |
| Close Tax Loopholes for Financial Institutions and Products | $4 | $3 |
| Close Tax Loopholes for Insurance Companies and Products | $13 | $12 |
| Reform Tax Accounting Methods to Close Tax Loopholes | $7 | $8 |
| Modify the Estate and Gift Tax Valuation Discounts | $24 | $3# |
| Other Revenue Changes | $1 | $1 |
| ***Revenue Increase in the President's Budget*** | ***$326*** | ***$300*** |
| Slow Growth of Provider Payments to Account for Productivity Increases | $110 | # |
| Phase-down Disproportionate Share Hospital (DSH) Payments | $106 | # |
| "Pay Better Prices" for Prescription Drugs in Medicare Part D | $75 | # |
| Adjust Payments for Imaging Services, Change Payments for Certain Inpatient Facilities, and Reduce Waste, Fraud, and Abuse | $22 | # |
| ***Offsets Announced on 6/13/2009*** | **$313** | # |
| ***Offsets in President's Budget*** | **$635** | **$597** |
| **TOTAL HEALTH CARE RESERVE FUND** | **$948** | # |

# = not yet fully-measured by the Congressional Budget Office or Joint Committee on Taxation

The Administration has already put forth around $950 billion in proposals representing a "down payment" on health reform. Nearly two thirds of this come from savings in Medicare and Medicaid, including cutting payments to Medicare Advantage, slowing the growth of provider payments, reducing subsidies to hospitals for treating the uninsured, and enacting a number of measures to reduce the cost of medicine and medical care. The remaining third comes from revenue measures – mainly by limiting itemized deductions for income over $250,000.

These offsets could go a long way to finance health reform, but more will be needed if current plans are not scaled back. Moreover, some of these proposals have been met with political resistance, and members of Congress have explored other means of financing health care reform.

Below, we have put together our own list of options, taken from a variety of sources, which could help to pay for the impending health care plan. We've divided these options into three charts – one dealing with options to scale back existing federal health care programs, one with options to reform provider payments and reduce overall health care costs, and one with ways to raise new revenue to pay for health care reform. These tables in no way represent an endorsement, but rather are meant to highlight the choices being presented in the current debate. Policy makers should carefully consider these options and others, making sure that health care reform reduces, rather than increases, our enormous budget deficits.

## CRFB Health Care Reform Series

***Five Principles for Responsible Health Care Reform***
***(http://www.crfb.org/documents/5_Principles_for_Health_Reform.pdf)***
***Principle #1: Slowing Health Care Cost Growth***
***(http://www.crfb.org/documents/Health_Principle_1.pdf)***
***Principle #2: Paying for Health Care Reform***
Principle #3: Making Medicare and Medicaid Sustainable
Principle #4: Addressing Other Areas of the Budget
Principle #5: Continued Vigilance in Health Care Reform

**Fig. 4: Options to Reduce Public Health Care Benefits (billions)**

| Policy | 5-year Savings | 10-year Savings | Description |
|---|---|---|---|
| **Change Programs to Vouchers** | | | |
| Adopt a Voucher Plan for Federal Employees Health Benefits | $7 | $37 | Under and a voucher plan or "premium support system," enrollees are provided with cash subsidies to purchase either public or private health insurance. |
| Convert Medicare to a Premium Support System | $44 | $161 | |
| **Medicare Eligibility Age** | | | |
| Raise the Age of Eligibility for Medicare from 65 to 67 | $3 | $86 | Currently, seniors are eligible for Medicare at 65. Raising the eligibility age would decrease the number of people covered by Medicare and incentivize later retirement. |
| **Federal Matching Rates (FMAP) for Medicaid** | | | |
| Reduce Floor on Matching Rates from 50% to 45% | $53 | $131 | In order to help finance Medicaid, the Federal Government pays state governments between 50% and 83% of their costs, depending on a formula which yields the federal medical assistance percentage (FMAP). Payments to states could be reduced to save money on the Federal level. |
| Remove Floor on Matching Rates | $88 | $228 | |
| Convert Federal Payments to Medicaid for Acute Care Services into Allotment (index to CPI) | $167 | $625 | |
| Convert Federal Payments to Medicaid for Acute Care Services into Allotment (index to health expenditure growth) | $51 | $189 | |
| **Medicare Advantage** | | | |
| Benchmark Reduction and Gradual Phase-Down | $20 | $79 | Medicare Advantage Plans allow beneficiaries to receive their Medicare benefits through private insurers. Since these plans currently cost the government more than traditional Medicare, a number of proposals could reduce Medicare advantage spending by bringing “benchmark” payments closer to those in the traditional program. |
| Establish Competitive Bidding for Medicare Advantage | $35 | $159 | |
| Set Benchmark for Private Plans in Medicare Equal to Local Per Capita Fee-for-Service Spending | $55 | $157 | |
| Eliminate One-Sided Rebasing Process for Establishing Benchmarks for Medicare Advantage Plans | $21 | $61 | |
| **Medicare Cost Sharing** | | | |
| Replace Medicare's Cost-Sharing Requirements with Unified Deductible, Uniform Coinsurance, and Catastrophic Limit | $7 | $26 | Although Medicare requires considerable cost-sharing, many enrollees pay for part of it through supplemental coverage known as Medigap. By restricting Medigap and/or increasing cost-sharing requirements, the government can make Medicare beneficiaries more cost-conscientious and reduce the federal burden. |
| Restrict Medigap Coverage of Medicare's Cost Sharing | $14 | $41 | |
| Impose a Surcharge on Medicare Cost Sharing in High-Cost Areas; Prohibit Medigap Plans from Covering the Surcharge | $6 | $21 | |
| Convert Medicare and Medicaid Disproportionate Share Hospital Payments into a Block Grant | $25 | $85 | |
| **Medicare Premiums** | | | |
| Increase Part B Premium to 35 Percent of Program's Costs | $64 | $217 | Medicare Parts B and D currently require enrollees to pay monthly premiums equal to 25 percent of costs (up to $2,250 for Part D). Certain wealthier individuals pay higher premiums for Part B. A number of proposals would increase premiums for some or all enrollees. |
| Require Manufacturers to Pay a Minimum Rebate on Drugs Covered Under Medicare Part D | $33 | $110 | |
| Increase Part D Premium for Higher-Income Enrollees | $2 | $10 | |
| Increase the Fraction of Part B Beneficiaries Who Pay Higher Income-Related Premiums | $5 | $21 | |
| **Military and Veteran's Benefits** | | | |
| Increase Medical Cost Sharing for Military Retirees | $1 | $5 | Currently, The federal government offers health benefits to active duty military personnel, their family, and certain classes of veterans. Some policies would modify eligibility rules or change benefit structures. |
| Introduce Minimum Out-of-Pocket Requirements in TRICARE | $14 | $40 | |
| End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8 | $12 | $26 | |

Sources: Congressional Budget Office and Authors’ Calculations

**Fig. 5: Options to Reduce Health Care Spending (billions)**

| Policy | 5-year Savings | 10-year Savings | Description |
|---|---|---|---|
| **Provider Payments in Medicare** | | | |
| Reduce Annual Updates in Medicare Fee-for-Service Payments to Reflect Expected Productivity Gains | $38 | $201 | The Medicare system bases its payment structure on a base payment system, which is updated every year to account for changing prices of various inputs. This system is used to calculate payments for physicians, nurses, hospitals, and other providers for various procedures and therapies. Many proposals would slow the rate at which payments are updated. |
| Reduce the Update Factor for Hospitals' Inpatient Operating Payments Under Medicare by 1 Percentage Point | $17 | $93 | |
| Reduce the Update Factor for Payments to Providers of Post-Acute Care Under Medicare by 1 Percentage Point | $9 | $54 | |
| Reduce the Update Factor for Medicare's Payments for Skilled Nursing Facilities by 1 Percentage Point | $4 | $24 | |
| Eliminate Inflation-Related Updates to Medicare's Payment Rates for Home Health Care for Five Years | $12 | $50 | |
| **Medicare Payment System** | | | |
| Reduce Medicare's Payment Rates for Hospitals in Areas with a High Volume of Elective Admissions | * | $3 | Many options exist which would reduce health care spending through reforming payment systems for Medicare. Some of these reforms provide incentives for hospitals to reduce the number and cost of services provided. Other reforms target hospitals in high-spending areas or those with high elective emissions, in order to reduce the geographic variation in Medicare's outlays for hospital services. |
| Reduce Medicare's Payment Rates Across the Board in High-Spending Areas | $12 | $51 | |
| Bundle Payments for Hospital Care and Post-Acute Care | $7 | $19 | |
| Improve Medicare home health payments to align with costs | $17 | $51 | |
| Reduce Medicare Payments to Hospitals with High Readmission Rates (readmission rates above 50th percentile) | $3 | $10 | |
| Pay Primary Care Physicians in Medicare Using a Partial-Capitation System, with Bonuses and Penalties | $1 | $5 | |
| **Other Reforms to Reduce Health Care Costs** | | | |
| Help Fund and Promote Comparative Effectiveness Research | $2 | $10 | A number of other reforms exist to reduce health care costs and promote greater efficiency. These range from promoting comparative effective research to loosening regulations on purchasing NonGroup Health Insurance, to limiting the awards plaintiffs can receive from medical malpractice lawsuits. |
| Allow Individuals to Purchase Non-group Health Insurance Coverage in Any State | $2 | $7 | |
| Limit Awards from Medical Malpractice Torts | $2 | $6 | |
| Require States to Use Community Rating for Small-Group Health Insurance Premiums | $2 | $5 | |
| Establish an Abbreviated Approval Pathway for Follow-On Biologics | * | $13 | |

* = less than $500 million

Note: Figures based on "scoreable savings" as defined by the CBO. Additional non-scoreable savings may be achieved from some policies.

Sources: Congressional Budget Office and Authors' Calculations

**Fig. 6: Options to Increase Revenue (billions)**

| Policy | 5-year savings | 10-year savings | Description |
|---|---|---|---|
| **Employer-Sponsored Insurance Tax Exclusion** | | | |
| Eliminate ESI Exclusion | $1,440 | $3,553 | Under current law, compensation received in the form of health insurance is untaxed, and this Employer-Sponsored Insurance (ESI) exclusion costs the government roughly $250 billion a year in lost revenue. Altering the ESI tax exclusion could generate considerable revenue. Options include eliminating the exclusion altogether, replacing it with a credit or deduction, or capping it in some way. |
| Replace ESI Exclusion with a Credit Indexed by CPI | $143 | $957 | |
| Replace ESI Exclusion with Credit Indexed by GDP | $79 | $470 | |
| Replace ESI Exclusion with a Credit Indexed by net personal healthcare spending growth | $0 | $66 | |
| Phase-out ESI Exclusion for Income over $250,000 a Year | $41 | $131 | |
| Cap ESI Exclusion at Average Cost of Health Insurance | $183 | $584 | |
| **Sin Taxes** | | | |
| Raise Cigarette Tax by $1 per Pack | $48 | $95 | Sin taxes aim to tax undesirable behavior. A number of revenue proposals for health care reform would use such taxes to discourage unhealthy behavior, both raising revenue and reducing long term health care costs. |
| Raise Alcohol Tax by $2.50 per Proof-Gallon | $28 | $60 | |
| Impose 3 Cent Tax on Sugar-Sweetened Beverages | $24 | $50 | |
| **Changes to the Payroll Tax** | | | |
| Increase Medicare Payroll tax by 1% | $210 | $592 | Currently, employers and employees pay a combined 2.9% of payroll to finance Medicare Part A. This tax could be increased or expanded in a number of ways. |
| Impose 1% Payroll Surtax on Income Above $150,000 | $27 | $77 | |
| Expand Medicare Payroll Tax to Cover Non-wage Income | $200 | $500 | |
| **Play or Pay** | | | |
| Impose $500 Tax on Employers Per Uninsured Worker | $13 | $47 | "Pay or play" policy options aim to encourage employers to offer health insurance by taxing those who do not. A number of proposals would impose such a tax. |
| Impose 6% Payroll Tax on Employers Per Uninsured Worker | $102 | $226 | |
| **Health Care Tax Benefits** | | | |
| Eliminate Health Savings Accounts | $5 | $11 | Under the current tax code, a number of health care-related benefits exist. For example, several types of accounts allow individuals to save tax free for health expenses. Additionally, special deductions exist for certain insurance companies. Curbing or eliminating these tax benefits could generate savings. |
| Eliminate Flex Savings Accounts for Uncovered Health Care | $27 | $60 | |
| Eliminate Blue Cross/Blue Shield Tax Deduction | $5 | $11 | |
| **Itemized Deductions** | | | |
| Limit the itemized deduction rate to 28% | $92 | $269 | In his Fy2010 Budget, the President proposed paying for part of his health care plan by limiting the extent to which higher earners can deduct certain activities such as mortgage interest and charitable giving. A number of options exist to make existing deductions cheaper and more progressive. |
| Replace Itemized Deductions with 15% Non-Refundable Credit | $582 | $1,487 | |
| Replace Itemized Deductions with 15% Refundable Credit | $497 | $1,263 | |
| **Value Added Tax (VAT)** | | | |
| Establish 2% Value Added Tax | $623 | $1530 | Some experts have proposed imposing a Value Added Tax (VAT) to help pay for health care costs. A consumption tax levied at each stage of production, a VAT is considered to be a comparatively low distortion tax which can raise significant amounts of revenue. |
| Phase-in 8% Value Added Tax (From 6.7%) | $2173 | $4968 | |

Sources: Congressional Budget Office, Lewin Group, Tax Policy Center, Citizens for Tax Justice, and Authors' Calculations